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APPLICATION FOR A CHANGE IN OWNERSHIP IN A CERTIFIED CHEMICAL DEPENDENCY SERVICE PROVIDER

Division of Alcohol and Substance Abuse (DASA)
Department of Social and Health Services (DSHS)
Olympia, Washington

Please complete **PARTS 1 through 6** of the application form, return the completed form with the completed information, and the required materials and $500 application fee.

PART 1 – CURRENT PROVIDER AGENCY INFORMATION (See instructions)

1. Agency Number
2. Name of Agency to Change Ownership (See instructions)
3. Additional Organizational Title of Agency to Change Ownership (See instructions)

PART 2 – TYPE OF OWNERSHIP CHANGE (See instructions)

4. Indicate below the type of change that will take place:	
☐	**a. Add one or more stockholder(s) of 5% or more of the corporate stock, or the transfer of stock of a current stockholder to a new stockholder of 5% or more of the corporate stock to an existing private for profit corporation.**
☐	**b. Add one or more partner(s) to an existing partnership who will own more than 5% of the partnership's organizational assets.**
☐	**c. Add one or more partner(s) to an existing limited liability company who will own more than 5% of a limited liability company's organizational assets.**
☐	**d. Change In type of ownership without adding any new owners of 5% or more of the organizational assets.**
☐	**e. Transfer of ownership from existing owner(s) to new owner(s).**

PART 3 – NEW PROVIDER INFORMATION (See instructions)

5. Will the new provider retain the same agency name?
   5a☐ Yes 5b☐ No

If no, indicate the new name of the agency and organization below:

6. Name of Agency to Change Ownership (See instructions)
7. Additional Organizational Title of Agency to Change Ownership (See instructions)

Type of New Ownership

8. Please indicate the new type of ownership for the proposed agency:

Publicly Owned:

☐	City Government	Name: _____
☐	County Government	Name: _____
☐	State Government	Name: _____
☐	Federal Government	Name: _____
☐	Tribal Government	Name: _____
☐	Health District	Name: _____
☐	Educational Service District	Name: _____
☐	Municipal Court Probation	Name: _____
☐	District Court Probation	Name: _____

Privately Owned:

☐	Sole Proprietorship	Name: _____
☐	Partnership	Name: _____
☐	Limited Liability Company	Name: _____
☐	Non-Profit Corporation	Name: _____
☐	For-Profit Corporation	Name: _____

All providers:

9. Federal Employer Tax Identification Number (FEIN) (May use Social Security Number (SSN) if Sole Proprietor):

☐ **FEIN** ☐ **SSN**	

10. What person or entity is the final authority for your organization and will be responsible for the governing body requirements of Washington Administrative Code (WAC) 388-805-140?

Name:	**Title:**

Note: This can be an entity, such as a tribal council, county commissioners, corporate board, etc.

Privately owned providers only:

11. Washington State Uniform Business Identification Number:

PART 3 – CHEMICAL DEPENDENCY SERVICES (See instructions)

12. DETOX AND RESIDENTIAL SERVICES	TOTAL # OF BEDS	SPECIAL TREATMENT FOCUS
☐ Detoxification - Acute		
☐ Detoxification - Subacute		
☐ Intensive Inpatient		
☐ Recovery House		
☐ Long-Term Treatment		
13. NON-RESIDENTIAL SERVICES	**ESTIMATED # OF PERSONS TO BE SERVED ANNUALLY**	**SPECIAL TREATMENT FOCUS**
☐ Outpatient		
☐ Intensive Outpatient		
☐ DUI Client Assessment		
☐ Alcohol/Drug Information School		
☐ Opiate Substitution Treatment		
☐ Treatment Alternatives to Street Crime (TASC)		
☐ Free-Standing ADATSA Assessments		
☐ Outpatient Childcare		
☐ Information and Crisis Services		
☐ Emergency Service Patrol		

PART 4- CONTRACTS

14. Does the agency now receive government funds, or do you intend to provide chemical dependency treatment services for which you may receive government funds?
☐ Yes ☐ No

15. If item 14 is yes, list the source(s), e.g., federal, state, tribal, county, criminal justice, corrections, or other: _____

16. Please list the certified chemical dependency treatment service(s) for which contract funds are or may be provided: _____

PART 5 – MATERIALS TO BE SUBMITTED WITH THE APPLICATION (See instructions)

A. **If you are adding one or more stockholder or partner to either a for-profit corporation, partnership, or limited liability company** then submit the following information:

1. **If privately owned**, a copy of the report of findings from a criminal background check, as conducted by the Washington State Patrol and the last state of residence if the person has lived out-of-state within the past three years for any new owner of five percent of the organizational assets.

2. **If privately owned,** a list with the name(s), address(es), telephone number(s), and percentage of ownership for each new owner of five percent or more of the organizational assets.

B. **If you are changing the type of ownership or transferring ownership from existing owners to new owners** then submit the following information:

1. A list with the name, address, telephone number, and title of each member of the new organizational governing body.

2. **If privately owned:**

   a. A list with the name(s), address(es), telephone number(s), and percentage of ownership for each new owner of five percent or more of the organizational assets.

   b. A copy of the report of findings from a criminal background check, as conducted by the Washington State Patrol and the last state of residence if the person has lived out-of-state within the past three years for any new owner of five percent of the organizational assets.

   c. A copy of the Washington State Master Business License, which authorizes the new organization to do business in this state.

3. Will the new governing body appoint a new administrator for the organization?
   3a☐ Yes 3b☐ No

Name:	**Title:**

If yes, list name and title above and submit a copy of the report of findings from a criminal background check, as conducted by the Washington State Patrol and the last state of residence if the new administrator has lived outside of Washington State within the past three years.

4. Will the administrator appoint a clinical supervisor for the organization?
   4a☐ Yes 4b☐ No

Name:	**Title:**

5. Will the new governing body approve and adopt the existing agency policies and procedures?
   5a☐ Yes 5b☐ No
   If no, submit a complete copy of the agency's new administrative, personnel, and clinical manuals specific to the organization, agency, and treatment services that will be in force in the agency at the time of the change in ownership.

6. Will the new provider adopt the existing fiscal policies and procedures?
   6a☐ Yes 6b☐ No
   If no, submit a copy of the agency's new fiscal policies and procedures as they relate to informing clients and patients of fees charged.

7. Will the new provider retain the same client care staff that are employed the current organization?
   Chemical Dependency Professional Staff 7c☐ Yes 7d☐ No

If no, submit evidence of sufficient qualified staff to deliver the chemical dependency treatment services that will be provided under the new ownership. Evidence must include:

a. A copy of an organizational chart showing each staff position, including volunteers, students, and persons on contract, by job title, lines of responsibility, the full-time equivalency percentage for each position, and how the agency relates to any parent organization.

b. A copy of the job description for the on-site administrator and each staff person who will be providing or supervising patient care.

c. A copy of the current certificate of certification as a Chemical Dependency Professional issued by the Washington State DOH for each chemical dependency professional to be employed by your organization at the proposed initial site.

   Note: The Chemical Dependency Professional wall certificate issued by DOH is not sufficient. The certificate must include the certification expiration date.

d. **If applying as a municipal or district court probation office**, submit evidence of the employment of a probation assessment officer that meets the requirements of WAC 388-805-220.

e. **If the agency is currently certified to provide alcohol/drug information school,** will the new provider retain the current alcohol/drug information school instructor?
   ☐ Yes ☐ No

   If no, then submit evidence of the employment of a qualified alcohol/drug information school instructor that meets the requirements of WAC 388-805-250.

C. All applicants:
1. **An application fee of $500** must be submitted with this application, and must be in the form of a check or money order made out to the Department of Social and Health Services.
2. A copy of the cover letter used to notify the county alcohol/drug coordinator for the county where services will be provided of this application.

PART 6 – DECLARATIONS (See instructions)

I will notify DASA if changes occur in any of the information provided in Parts 1 through 6 of this application before certification occurs.

I declare that the agency policy and procedures manual will be revised to reflect any organizational changes or changes in business and clinical practices under the new ownership within 3 months of the date of departmental approval of the changes in ownership.

I declare that no person named in this application has had a license or certification for a chemical dependency treatment service or health care agency denied, revoked, or suspended, as referenced in WAC 388-805-065(1)(a).

I declare that no person named in this application has been convicted of child abuse or adjudicated as a perpetrator of substantiated child abuse, as referenced in WAC 388-805-065(1)(b).

I declare that no person named in this application is currently under investigation for having committed, permitted, aided or abetted the commission of an illegal act or unprofessional conduct as defined under Chapter 18.130.180 RCW, as referenced in WAC 388-805-065(1)(d).

I declare I have read the privacy notice at the end of this application.

I declare that the information contained in this application and on all documents submitted with this application is true, accurate, and complete to the best of my knowledge.

Signature of former owner or other responsible party	**Date**
Address	**Telephone** **( )**
Type or Print Name	**Title**
Signature of new owner or other responsible party	**Date**
Address	**Telephone** **( )**
Type or Print Name	**Title**

Return the original application form, one copy of the items required in **PART 5**, and the nonrefundable $500 application fee to the attention of:

Robert Geissinger, CCDCIII, Certification Specialist
Certification Section
Department of Social and Health Services
Division of Alcohol and Substance Abuse
Post Office Box 45330 (Mail Stop 45330)
Olympia, Washington 98504-5330

Note: You do not have to return the instructions with your application. Program manuals will be returned to the applicant after they are reviewed.

Privacy Notice

This notice is provided in compliance with Governor's Executive Order 00-03 and addresses the collection, use, security, and access to information obtained by your submission of this application or request.

DASA requires an applicant who is applying for certification to provide chemical dependency services as a sole proprietor to submit a Federal Employer Tax Identification Number or their personal Social Security Number. The number is used to identify a specific person or legal entity that owns a specific business.

DASA also requires an applicant to submit the name, address, and telephone number for each owner of 5% or more of the organizational assets. Additionally, we require owners and the administrator to submit copies of the results of a criminal background check conducted by the Washington State Patrol. This information will be used to determine whether a specific person is a qualified applicant under WAC 388-805-065.

Applicants may decide to provide personal contact information (address, or telephone number) in lieu of business contact information. Addresses and telephone numbers identified as personal information and criminal background checks may be disclosed to parties outside of the department without written consent of the involved party.

All information collected as a part of the application or a request for departmental approval is collected for considering applicant and provider compliance with applicable regulations related to their requests. All information is considered public information, and may be made available to anyone submitting a proper public information request unless exempted by the Public Information Disclosure Act under Revised Code of Washington 42.17.310(1).

Information may be retained for the period of provider certification to include any subsequent changes in provider ownership. The department will retain records for up to six years following the voluntarily cancellation of certification, and indefinitely in cases of involuntary cancellation, revocation, or suspension of certification. Information will be destroyed after that time.

Persons submitting information have the right to review personal information on file with the department. You can recommend changes to your personally identifiable information you believe to be inaccurate by submitting a written request that credibly shows the inaccuracy. We will take reasonable steps to verify your identity before granting access or making corrections.

Please contact Bob Geissinger if you have any questions or concerns. Contact information is provided with this application.

(f:\shared\certification\forms\123a revised 9/9/2003)